

SUFFERING IN SILENCE:

**A Report on the Inadequacies of the Care Provided By Mental
Health Community Residential Facilities (MHCRFs) and
Case Management Services Funded by the
District of Columbia Department of Mental Health**

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| | |
|--|----|
| INTRODUCTION..... | 3 |
| METHODOLOGY..... | 4 |
| DEFINITIONS..... | 5 |
| FINDINGS: | |
| I. CONSUMERS HAVE BEEN VERBALLY ABUSED AND SIMILARLY MISTREATED IN MHCRRS..... | 5 |
| II. CONSUMERS HAVE BEEN DISCRIMINATED AGAINST IN MHCRRS..... | 7 |
| III. CONSUMERS HAVE BEEN REFUSED ENTRANCE TO MHCRRS..... | 8 |
| IV. SOME PROVIDERS, ACTING AS REPRESENTATIVE PAYEE, HAVE ABUSED THEIR RESPONSIBILITIES..... | 10 |
| V. CONSUMERS IN MHCRRS DO NOT RECIEVE BASIC NUTRITION OR SPECIAL DIETS REQUIRED FOR MEDICAL REASONS..... | 13 |
| VI. MHCRRS DO NOT HAVE ENOUGH SUPPLIES..... | 15 |
| VII. MHCRRS ARE UNDERSTAFFED..... | 16 |
| VIII. MHCRRS DO NOT PROVIDE A HOME-LIKE ENVIRONMENT..... | 17 |
| IX. CONSUMERS ARE AT RISK..... | 18 |
| X. CASE MANAGERS HAVE PLACED CONSUMERS IN AND NEGLIGENTLY ALLOWED CONSUMERS TO REMAIN IN UNINHABITABLE AND UNSAFE HOUSING..... | 19 |
| XI. MHCRRS FAIL TO PROVIDE ACTIVITIES..... | 21 |
| XII. MHCRRS HAVE ARBITRARY RULES..... | 23 |
| XIII. CONSUMERS ARE BEING DENIED THE LEAST RESTRICTIVE SETTING..... | 24 |
| CONCLUSION..... | 26 |
| ATTACHMENT: DMH PROTOCOL LETTER | |

INTRODUCTION

University Legal Services, Protection and Advocacy (ULS-P&A) has written the following report in order to share with providers, fellow advocacy groups, and interested parties our concerns regarding the inadequacy of care provided to individuals with mental illness in the District and also to provide recommendations toward improving such care. Specifically, this report focuses on the care provided by Mental Health Community Residence Facilities (MHCRFs) and case management services funded by The Department of Mental Health.

In July 2001, the Office of the D.C. Auditor released a report entitled, *Health and Safety of the District's Mentally Ill Jeopardized By Program Deficiencies and Inadequate Oversight*. The Auditor's report focused on deficiencies in the licensing and monitoring of MHCRFs by the D.C. government agencies responsible for oversight. The Auditor's report also included a short section citing inadequacies in the services and care being provided in MHCRFs. The following report expands on this section of the Auditor's report, providing a more detailed discussion and examples of specific inadequacies in services and care.

In the *Multi-Agency Preliminary Corrective Action Plan In Response to the DC Auditor Report*, DMH stated specific corrective actions it would take regarding the services and care provided in MHCRFs and regarding the reporting and investigation of grievances. To date, DMH has failed to take substantial action towards actualizing those corrective intentions. As a result, little appears to have changed from the time of the Auditor's report, which was released prior to the transition of licensing and monitoring from the Department of Health (DOH) to DMH, and the present, many months after DMH assumed responsibility via enabling statute.

Here are some of the major abuses and inadequacies in care and service ULS-P&A found in many MHCRFs over the course of the last year:

- Consumers have been abused and discriminated against;
- Consumers have been refused entrance to MHCRFs during the day;
- Various providers, acting as representative payees, have abused their responsibilities in managing consumers' finances;
- Consumers have not received basic nutrition or special diets required for medical reasons;
- Many MHCRFs do not have or provide enough household supplies;
- A large number of MHCRFs are understaffed;
- Most MHCRFs visited did not provide a home-like environment;
- Consumers are particularly susceptible to heat related-injuries and are commonly and unnecessarily placed at risk living in MHCRFs without air-conditioning;
- Many case managers have placed consumers in and negligently allowed consumers to remain in uninhabitable and unsafe housing;
- Many MHCRFs fail to provide habilitative social and recreational activities;
- Various MHCRFs have arbitrary rules that unnecessarily limit consumer choice and freedom;

- Consumers are frequently denied their legal right to live in the least restrictive setting.

The recommendations in this report center around the need for the following:

- Monitoring of all MHCRFs must be increased in order to address and prevent abuse and neglect;
- DMH needs to *enforce* the legal requirements governing both MHCRFs and case managers through explicit, consistent consequences;
- A uniform grievance procedure must be established and case managers, MHCRF owners and staff, and consumers must be informed as to how to initiate and use the grievance procedure;
- Case managers must be properly and comprehensively trained and held accountable for inspecting community placements before placing consumers and should also continuously work with consumers and their care providers to ensure that consumers are in the least restrictive setting;
- MHCRF staff must receive the training, supervision, and support necessary to work with residents in a positive, supportive manner;
- Licensing of MHCRFs must take into account the quality of rehabilitative services, supportive counseling, and social and recreational activities that are to be provided for consumers;
- Consumers must be allowed and encouraged to become involved in the management of their personal finances, decisions about daytime activities, MHCRF menu planning, and the creation of MHCRF house rules;
- Sanctions are applied to MHCRFs that fail to comply.

METHODOLOGY

As the District of Columbia's protection and advocacy program, ULS-P&A investigates allegations of abuse and neglect of individuals with mental illness receiving services in the District. The findings in this report reflect ULS-P&A's experiences with various (but not all) MHCRFs, case managers, and consumers while conducting investigations and, accordingly, is not intended to be an overview of the care provided in all MHCRFs.

The findings are a synthesis of accounts of abuse and neglect received by ULS-P&A and the corresponding investigations over a period of approximately a year and a half, beginning in August 2000. Over that year and a half, ULS-P&A visited approximately 21% of licensed MHCRFs in the District of Columbia. ULS-P&A typically receives complaints from consumers, family members of consumers, treatment providers, and fellow advocates. The information in this report was primarily gathered through interviews with consumers, MHCRF staff, and with case managers. Data was also garnered by reviewing consumer records, and by visiting MHCRFs and other consumer residences. ULS-P&A gathered additional information through administering a survey to DMH consumers at senior day treatment programs.

All consumers referred to in this report receive services from either DMH or a provider under a contractual relationship with DMH. Pseudonyms were used to protect the identity of individuals whose experiences of abuse and neglect are included in this report.

DEFINITIONS

The Department of Mental Health (DMH): The Department of Mental Health was created as an agency by enabling legislation during 2001. DMH was formerly called The Commission on Mental Health Services. The 2001 enabling legislation gave DMH control and responsibility for licensing and monitoring of all MHCRFs, a responsibility previously held by the District of Columbia's Department of Health.

Mental Health Community Residence Facility (MHCRF): MHCRFs are supervised group homes, designed to provide supportive, home-like environments in the community for individuals with mental illness. There are approximately 165 licensed MHCRFs in the District of Columbia.

Case Manager: Case managers help connect consumers to services, coordinate consumers' services, and advocate on consumers' behalf. All DMH consumers have a case manager either directly through DMH or through a private company under contract with DMH.

FINDINGS

I. CONSUMERS HAVE BEEN VERBALLY ABUSED AND SIMILARLY MISTREATED IN MHCRFS

The law: Chapter 38 of the D.C. Municipal Regulations provides that, "Each resident shall have a right to receive adequate and humane treatment by competent, qualified, professional staff." D.C. Mun. Reg. tit. 22 §3801.8(1995). The Regulations additionally require that, "Each Residence Director shall thoroughly investigate any allegations of mistreatment by an MHCRF employee... and promptly report any findings or actions taken as a result of the investigation to the resident." D.C. Mun. Reg. tit. 22 §3820.6(1995).

ULS-P&A has received complaints that consumers have been verbally abused, sexually harassed, and similarly mistreated in MHCRFs. For example, staff and owners have told consumers that they are "fat" or "stupid." ULS-P&A has twice witnessed an owner or a staff member launch into a tirade about a consumer in the consumer's presence. According to ULS-P&A's survey, three consumers at a day treatment program reported that members of staff are "mean" to them and two consumers at another day treatment program reported that members of staff often "yell at them." Consumers and

MHCRF staff are often hesitant or afraid to report abuse. Indeed many of the instances of abuse were discovered while interviewing staff or residents during investigations of unrelated complaints. As a consequence, ULS-P&A is seriously concerned that abuse in MHCRFs is considerably under-reported. The following are examples of abuse, sexual harassment, and similar mistreatment in MHCRFs:

- The owner of the residence regularly belittled consumers in one MHCRF. For example, when they voiced concerns about the lack of food, they were told they were “fat” and needed to be on a diet anyway.
- In regard to another MHCRF, three separate sources confirmed that a staff person was verbally abusive towards residents. In response to ULS-P&A’s complaints, the MHCRF owner merely stated that the staff person is one of her best employees and that she is misunderstood because she has a loud voice. ULS-P&A reported the situation to DMH and DOH, but never received any written response.
- ULS-P&A received a complaint from several sources that a female staff member was sexually harassing a male consumer in his MHCRF. In one instance, the staff member reportedly walked into the bathroom when the resident was undressed and made comments about the male residents’ genitalia when residents could easily overhear her. Two sources told ULS-P&A that they had reported the situation to the MHCRF owner and that the owner dismissed the complaints in a verbally hostile manner.

Abuse in MHCRFs is against the law and there must be a “zero tolerance” policy against abuse in MHCRFs. MHCRFs were designed to provide a therapeutic and supportive environment for consumers. Abuse, in addition to being illegal, creates a hostile and alienating living environment. In the past, DOH and DMH have conducted inadequate investigations into advocates’ reports of abuse. For example, in response to an allegation that a staff person was abusing a resident, DOH interviewed staff and the owner, but did not interview any of the residents. In DMH’s response to the Auditor’s report, it stated that it was developing “grievance procedures...to assure that prompt and comprehensive investigation...and remediation processes are implemented...” (p. 6). To date, ULS-P&A is not aware of any comprehensive grievance procedure that has been developed by DMH.

To decrease the incidence of abuse, sexual harassment, and similar mistreatment in MHCRFs, ULS-P&A recommends that:

1. DMH must initiate and enforce mandatory reporting requirements for any MHCRF or case manager who believes a consumer has been abused or neglected;
2. MHCRF employees be screened before employment for any history of abusive behavior, as required by Chapter 38;
3. Any MHCRF employee who has been abusive towards a consumer be *immediately* removed from the residence;

4. All MHCRF employees receive adequate training and supervision;
5. MHCRFs obey labor laws regulating the number of hours and shifts that employees can consecutively work;
6. A uniform grievance system be established and made known to all DMH consumers, employees, and contract employees; and
7. Investigators, monitors, and case managers receive proper training on the warning signs of abuse and how to effectively investigate complaints of abuse.
8. Sanctions are applied to MHCRFs that fail to comply.

II. CONSUMERS HAVE BEEN DISCRIMINATED AGAINST IN MHCRFS

The law: Chapter 38 of the D.C. Municipal Regulations provides that, "Each resident shall receive treatment and services...without discrimination in the quality or quantity of a service based on...physical or mentally disability, HIV status...." D.C. Mun. Reg. tit. 22 §3801.2(1995).

ULS-P&A has received complaints involving discrimination against consumers in MHCRFs based on their disabilities. For example, consumers have been denied services based on their HIV status and on symptoms resulting from psychiatric medication. Indeed, consumers have even been denied admission to MHCRFs based on their HIV status. The following examples illustrate discrimination in MHCRFs:

- A MHCRF house manager forced Ms. Owens to buy bleach and gloves because of Ms. Owens' HIV status. Ms. Owens additionally alleged that the house manager told other residents about her HIV status.
- Ms. Jordan, a resident of another MHCRF, has difficulty eating because she suffers from Tardive Dyskinesia. Tardive Dyskinesia is a side effect of some anti-psychotic medications, which can, as in Ms. Jordan's case, result in uncontrollable, jerky movements. Ms. Jordan and her case manager reported that the MHCRF owner twice refused Ms. Jordan food and even verbally humiliated her, claiming that she did not "eat appropriately." ULS-P&A sent a complaint to DMH, but never received a response.

Consumers are forced to deal with discrimination based on their disability regularly while in the community. In contrast, MHCRFs are legally mandated not to discriminate and are designed to provide consumers with a home where they are accepted and understood. Obviously therefore, owners and supervisory staff of MHCRFs must have the level of training and sensitivity necessary to understand the challenges consumers face because of their disabilities, and, most trenchantly, staff and owners must treat all consumers without discrimination.

To prevent discrimination against consumers in MHCRFs, ULS-P&A recommends that:

1. All MHCRF employees receive mandatory anti-discrimination training;
2. All residents be informed as to what constitutes discrimination and instructed as to how they can file a grievance if they feel they have been discriminated against; and
3. A uniform grievance system be established and made known to all DMH consumers, employees, and contract employees;
4. Sanctions are applied to MHCRFs that fail to comply.

III. CONSUMERS HAVE BEEN REFUSED ENTRANCE TO MHCRFS DURING THE DAY AND OVERNIGHT

The law: Chapter 38 of the D.C. Municipal Regulations requires that, “Each Supported Residence shall maintain at least one (1) staff person at the residence, whenever a resident is present.” D.C. Mun. Reg. tit. 22 §3835.5(1995). The Regulations additionally provide that, “Residents may remain in the residence, work or participate in a structured day program, or other daily activity. Attendance in a day program shall not be mandatory for persons seeking placement in a Supported Residence.” D.C. Mun. Reg. tit. 22 §3835.8(1995). Furthermore, “Nothing...shall be construed to permit a Residence Director to require residents to attend day programs or activities or to be absent from the facility during the day, particularly during periods of medical illness.” D.C. Mun. Reg. tit. 22 §3818.6(1995).

Over the past year and a half, ULS-P&A has received numerous reports of consumers being locked out of MHCRFs during the day. Specifically, consumers have been told that they could not be in their residence from morning until late afternoon because there was no staff at the residence to supervise them. Rather than hire an adequate number of staff to provide coverage of the residence during the day, many MHCRFs have forced consumers to attend day programs or remain away from the residence for most of the day. Approximately 25% of consumers that ULS-P&A surveyed at senior day treatment programs reported they have “had to wait outside because staff were not at the CRF.” In addition to complaints about being refused entrance during the day, ULS-P&A has even received reports of consumers being refused entrance to their MHCRF *overnight*. The following examples illustrate such situations:

- Mr. Green and Mr. Sayle reported they had to be out of their MHCRF by 8:00 a.m. every day and could not return until after 3:00 p.m. because there was no staff available during the day. The two men’s case managers confirmed their complaints. Mr. Green was between jobs and Mr. Sayle was waiting for a vocational program to begin, therefore, they had nowhere to go during the day. ULS-P&A filed *several* complaints with DMH, but *never* received a response.

- ULS-P&A received a complaint that Ms. Mitchell and Ms. Smith were forced to remain out of their residence from approximately 9:00 a.m. to around 2:30 p.m. everyday. Reportedly, the owner told the two women they could not return to residence during the day because they were costing her too much money and that consequently she (the owner) had to get a job. When ULS-P&A attempted to visit the MHCRF at 5:30 p.m. on a Friday evening, we found that there were no staff or consumers present.
- Mr. Turner was refused entrance to his MHCRF at 4 a.m. and was forced to remain outside until later that morning. The owner of the MHCRF reported that she did not allow Mr. Turner in the house because it was after curfew time.
- A consumer at another MHCRF told ULS-P&A that if a resident returns to the house after 9:00 p.m., then the staff would not let them in until the morning. As a result, they are forced to remain outside or find shelter elsewhere. This MHCRF is located in an area where the crime rate is reported to be among the highest in the city.

DMH has interpreted the Chapter 38 regulations to require *that no resident ever be locked out of their MHCRF during the day*. The following is a quote from a memorandum circulated in June 1998 by DMH, then known as the Commission on Mental Health Services, explaining that consumers are not to be refused entrance to their residence:

It has been reported that consumers are required to attend day programs and/or be out of their homes during the day. Additionally, it has been reported that even when consumers have been out, there are many instances [when] no staff [member] is present to let them back in after their program is over. This practice is inconsistent with the requirements of Chapter 38 of the CRF regulations, which requires that staff be present at all times when consumers are present, and that consumers cannot be required to attend programs in order to live in their homes.¹

Now, almost four years after DMH's letter was circulated, the problem continues. To date, as explained previously in this report, ULS-P&A has seen no evidence of the implementation of any grievance procedure developed by DMH to effectively address this problem. While we wait, not only are MHCRFs violating the consumers' rights, but they are also placing residents at considerable risk of harm. When locked out of their homes, consumers are without supports, subject to extreme weather and easy prey for criminals. Additionally, if there are no staff members on shift to let consumers into their residences, then it follows that no accommodations could be made for consumers when they are sick or cannot attend their day program. In fact, directors and staff at day

¹ A copy of this letter is been provided at end of report

programs have, at times, not been able to contact some MHCRF operators to inform them that a consumer was ill, and therefore, the consumers had to remain at the day program. Even more shocking is the fact that consumers have been refused entrance overnight, being forced onto the street in crime infested areas.

ULS-P&A recommends that:

1. Monitoring of MHCRFs be increased;
2. DMH impose consistent sanctions, such as fines, on MHCRFs that refuse consumers entrance; and
3. The notion of Consumers' Choice is made real and meaningful by supporting consumers who want to pursue day activities other than, or in addition to, day programs, such as employment;
4. Sanctions are applied to MHCRFs that fail to comply.

IV. SOME PROVIDERS, ACTING AS REPRESENTATIVE PAYEE, HAVE ABUSED THEIR RESPONSIBILITIES IN MANAGING CONSUMERS' FINANCES, RESULTING IN FINANCIAL EXPLOITATION AND LOSS FOR CONSUMERS

The law: The Social Security Administration Handbook §1615 requires a representative payee "to use the benefits in the best interests of the beneficiary." Additionally, §1906.1 of the handbook declares that, "The representative payee is personally liable if he or she: 1) Was at fault in creating the overpayment; or 2) Did not apply the monies for the beneficiary's use and benefit." Chapter 38 of the D.C. Municipal Regulations requires that, "Each MHCRF shall provide for educational and skill building activities...which promote the development of...money management." D.C. Mun. Reg. tit. 22 §3834.4(1995).

DMH has failed to adequately safeguard consumers' funds, regularly update consumers about their accounts, and provide consumers with choice regarding how their money is spent. Consumers often contact ULS-P&A because they have not received their \$70 per month Personal Needs Allowance. Commonly, the reason that the consumer has not received his or her Personal Needs Allowance is that the Social Security Administration (SSA) determined the consumer to have received an overpayment. An overpayment is money received from SSA above what the consumer is eligible for, *or* money received from SSA by a consumer who has more than \$2000 in savings for six months. When a consumer has a representative payee, an overpayment can only occur if the representative payee failed to inform SSA of changed circumstances or if the representative payee allowed the consumer's account balance to remain greater than \$2000 for six months or longer (this assumes there was no error by SSA). It is the responsibility of representative payees to inform SSA of any circumstances that may change the amount of money the beneficiary receives and to monitor the account balance.

Conversely, consumers are rendered powerless to avoid the accumulation of money in their account.

The following are examples of circumstances in which consumers' funds were inadequately managed:

- Ms. Grady had not received her Personal Needs Allowance. She stated that she did not understand why and asked for ULS-P&A's help to rectify the situation. DMH is her representative payee, so ULS-P&A contacted the DMH case manager. ULS-P&A was told that Ms. Grady had an overpayment that her case manager had not been aware of, and as a result, SSA had taken all of the money in Ms. Grady's account, leaving her with a balance of \$0. Through investigating, ULS-P&A discovered that her representative payee allowed Ms. Grady's balance to *remain over \$2000 for an entire year without taking any necessary action.*
- Ms. Sweeney and Ms. Nathan reported to ULS-P&A that for the approximately nine months that they have resided in a MHCRF, they have never received a Personal Needs Allowance and that they do not know who manages their funds. Additionally, Ms. Nathan said that when she moved into the MHCRF she had a debit card, but it was taken from her and she does not know why or where it is.
- Mr. Young were living in an unlicensed MHCRF, the owner of which was his representative payee. Mr. Young did not know how much his monthly Social Security check was, nor did he know how much his rent was. ULS-P&A contacted SSA. SSA investigated and found that SSA had not known where Mr. Young was living for over a year because the representative payee had not notified the SSA about Mr. Young's change of address. Compounding the problem, the representative payee had fraudulently been collecting the State Supplement for MHCRF level of care, when, in fact, the residence was a boarding house.
- As reported by the MHCRF owner, Mr. William's DMH case manager, who is responsible for managing his SSA benefits, has not paid Mr. William's rent for several months. Mr. William's placement is in jeopardy as a result.
- Mr. McCoy, who lives in public housing, got an eviction notice because his case manager had not paid his rent in four months. Additionally, Mr. McCoy is being charged late fees. This is not the first time Mr. McCoy's case manager has failed to pay his rent. On a prior occasion, Mr. McCoy had to go to landlord-tenant court to try to resolve recurring financial problems with his landlord caused by non-payment of rent.

- Mr. Cole lives in his own apartment and has a case manager through DMH. His case manager acts as his representative payee on behalf of DMH and is responsible for paying his rent. As of July, 2001, Mr. Cole's case manager had not paid his rent for several months. As of December, 2001, Mr. Cole's building manager reported that the rent has still not been paid in full.
- Ms. Johnson told ULS-P&A that she needed to go shopping for winter clothes, but that she did not know how much money was in her account. ULS-P&A contacted patient accounts at DMH and discovered that Ms. Johnson had close to \$2000 in her account. ULS-P&A contacted Ms. Johnson's case manager, who was also her representative payee, to inform her that the account was running close to a balance of \$2000 and that Ms. Johnson wanted to go shopping for winter clothes. The case manager was unaware of how much money was in Ms. Johnson's account. Once informed, she told ULS-P&A that she planned to avoid an overpayment by using the money to start a burial fund for Ms. Johnson, not to buy clothes.
- Mr. Nelson complained that his case manager provided him with only \$4 a day, which had to cover food, transportation, etc. Upon review of Mr. Nelson's financial records, it was revealed that one of the reasons he was receiving so little money was because he was paying back a huge overpayment to SSA. The case management agency, which was also his representative payee, admitted they had neglected to appeal the overpayment and had not gone to the SSA office to negotiate more acceptable repayment terms. It was further discovered that part of the overpayment was the fault of Mr. Nelson's previous case management provider and representative payee, who had inappropriately charged SSA for a MHCRF level of care while Mr. Nelson was actually living in a Supported Independent Living residence.

The above detailed negligent and, in some cases, deliberate actions are unacceptable due to the level of hardship and stress they cause consumers. Consumers receiving Social Security benefits are on a very limited budget. Consumers in MHCRFs typically receive a Personal Needs Allowance of only \$70 a month. Loss of, or reduction in, such a small but vital monetary allowance leaves consumers without funds for basic needs. The most trenchant point is that the resulting stress and frustration imposed on consumers is entirely avoidable. Case managers frequently tell ULS-P&A that they do not receive timely, necessary, or even accurate information from the Office of Patient Accounts, which is run by DMH. In DMH's response to the D.C. Auditor's Report, DMH stated that a financial oversight program would be developed and staff would be trained prior to October, 2001. To date, ULS-P&A is unaware of any such program developed by DMH and has yet to see any improvement in the performance of representative payees and the Office of Patient Accounts.

Under a habilitative approach to services, representative payees work with the consumer towards the goal of the consumer managing their money independently.

Currently however, most consumers are not being provided information about their accounts and are not involved in deciding how to spend their money. Furthermore, consumers who could manage their money independently or with minimal assistance have representative payees for the convenience of providers, particularly MHCRF operators. As a result, DMH and representative payees are taking power and choices away from consumers rather than facilitating independence.

ULS-P&A recommends the following changes in order to protect consumer funds and facilitate independence:

1. Decentralize the representative payee system so that the accounts of consumers living in the community are not managed by the Office of Patient Accounts;
2. Provide training for case managers on public entitlements and the responsibilities of representative payees;
3. Include performance as a representative payee in the performance evaluation of DMH employees (or contractors if the function is contracted out);
4. Establish a system of accountability for representative payees under contract with DMH, putting the onus for mistakes on the representative payee;
5. Never allow a consumer to be charged a late fee for rental or other payments when late payment or non-payment occurs through the negligence of the representative payee;
6. Provide *consumers* with monthly statements about their accounts; and
7. Include achievable money management goals in consumers' treatment plans;
8. Sanctions are applied to MHCRFs that fail to comply.

V. CONSUMERS IN MHCRFS DO NOT RECEIVE BASIC NUTRITION OR SPECIAL DIETS REQUIRED FOR MEDICAL REASONS

The law: Chapter 38 of the D.C. Municipal Regulations require that: Each MHCRF shall serve, provide for, or arrange on a daily basis at least three (3) meals and between meals snacks that meet one hundred percent (100%) of the required daily allowance as defined by the Food and Nutrition Board of the National Academy of Science and are suited to the special needs of each resident, and adjust meals and snacks for seasonal changes, particularly to allow for the use of fresh fruits and vegetables. D.C. Mun. Reg. tit. 22 §3813.3(1995). The Regulations also require that, "Each MHCRF with residents who are in need of special or therapeutic diet shall ensure that the diet is planned, prepared, and served as prescribed by the attending physician." D.C. Mun. Reg. tit. 22 §3814.1(1995).

Many consumers in MHCRFs do not receive proper nutrition and do not have access to medically required foods. ULS-P&A has received reports of consumers buying food or bringing food home from day programs to supplement meager meals. Consumers have reported that they are rarely to never served fresh fruits, vegetables, or milk. When visiting MHCRFs, ULS-P&A has found sparsely stocked pantries and refrigerators and

observed grossly inadequate meals. But worst of all, there have been incidents in which MHCRFs were not supplied with consumers' medically required diets, and special but vital medical instructions such as "no juice" for a diabetic consumer were routinely ignored. Additionally, many consumers live in MHCRFs for decades, eating the same meals week after week and, in ULS-P&A's survey, over 50% of consumers who responded reported that they have no choice as to what food is served. The following examples illustrate MHCRFs' failure to provide required dietary services:

- The consumers at one MHCRF have had continual problems with lack of food. On the evening of a visit from ULS-P&A, the menu listed spaghetti and Kool Aid, but consumers were served cold chicken salad and boiled cabbage because the house lacked the necessary ingredients for the menu items. For dessert the consumers shared a box of cookies one had won in a bingo game at her day program. Staff and consumers say that they continually run out of basic foodstuffs, such as butter and sugar, making it difficult to prepare meals. The consumers and staff reported that they never receive high quality meat, but always some frozen version of turkey or hamburger. ULS-P&A was told that rice and turkey wings are served almost ad nauseum, and this despite the fact that many consumers had difficulty eating because they wear dentures. Apparently, even the turkey wings suffer from rationing as, at one dinner, the residents were served only one turkey wing each.
- At the same MHCRF, one of the consumer's blood sugar level dropped to a dangerously low level on at least two occasions, and on one of these occasions there was neither orange juice nor sugar available in the residence. DOH has confirmed that this MHCRF consistently lacks food items that the residents require for medical reasons.
- During a visit to another MHCRF, it was observed that dinner consisted of hot dogs, canned beans, and water, notwithstanding that the posted menu called for turkey and gravy, mixed vegetables, bread and butter, and juice.
- ULS-P&A received a report that at another MHCRF the meals on one day consisted of grilled cheese and coffee for breakfast, a baloney sandwich for lunch, and a small bowl of fried rice for dinner. It was further reported that there was also a bowl of apples on the table, but the consumers wore dentures and therefore could not eat the apples.

Failure to provide basic nutrition is indicative of overall neglect within MHCRFs. In the case of the diabetic resident without access to juice or sugar, this neglect is life threatening. It is unlikely that a MHCRF, which fails to provide decent meals, is providing a supportive, home-like environment. Even amongst MHCRFs that do provide basic nutrition, it is unusual to find a residence that provides consumers with menu choice or involves consumers in menu planning.

ULS-P&A recommends that:

1. Monitoring of MHCRFs include unannounced visits and consumer interviews in order to help enforce dietary requirements;
2. Consumers be provided a *variety* of fresh foods and menu choices;
3. Each MHCRF have a system of resident evaluation of the food and allow consumers to be involved in menu planning; and
4. Sanctions are applied to MHCRFs that fail to comply.

VI. MHCRFS DO NOT HAVE ENOUGH HOUSEHOLD SUPPLIES

The law: Chapter 38 of the D.C. Municipal Regulations requires that, "Each toilet room or lavatory shall be adequately equipped with...toilet paper...soap...adequate lighting...." D.C. Mun. Reg. tit. 22 §3808.2(1995). The Regulations also require that, "Each MHCRF shall provide appropriate...equipment to ensure...proper sanitary washing and handling of ...personal clothing of residents." D.C. Mun. Reg. tit. 22 §3815.2(1995). The Regulations further require that, "Each room in a MHCRF shall have adequate light." D.C. Mun. Reg. tit. 22 §3804.1(1995).

Many MHCRFs are not stocked with basic household supplies. Consumers report a shortage of supplies such as toilet paper, other paper products, laundry soap, and light bulbs. The following examples illustrate the problem:

- The MHCRF where Ms. Grady lives has had consistent difficulty keeping the house stocked with supplies. Ms. Grady reported that when she told the owner of the house that they were out of laundry detergent, she was told to go wash her clothes in the creek. Ms. Grady and the other consumers in the house also reported a shortage of paper products, cleaning supplies, and light bulbs.
- Mr. Sayle reported to ULS-P&A that his MHCRF expects him to buy his own soap and toilet paper and that he had to replace a burned out light bulb in the bathroom with his own money.
- Ms. Owens reported that she was continually forced to buy her own soap and toilet paper using her \$70 a month personal needs allowance.

Residents of MHCRFs typically receive only \$70 per month for their Personal Needs Allowance. Out of this \$70, they have to pay for transportation, personal hygiene supplies, recreational activities, and various other expenses. If residents have to pay for household supplies, they would have tremendous difficulty covering their personal expenses. Additionally, MHCRFs which fail to provide such basic supplies surely also fail to provide a supportive, rehabilitative, home-like environment for consumers.

ULS-P&A recommends that:

1. Monitoring of MHCRFs include unannounced visits and consumer interviews in order to determine if there are sufficient supplies; and
2. Sanctions are applied to MHCRFs that fail to comply.

VII. MHCRFS ARE UNDERSTAFFED

The law: Chapter 38 of the D.C. Municipal Regulations require that, “Each Supported Residence shall maintain at least one (1) staff person at the residence, whenever a resident is present and a 1:8 staff-to-resident ratio during times of peak activity, such as mealtimes.” D.C. Mun. Reg. tit. 22 §3835.5(1995). The Regulations also require that, “Each Supported Rehabilitative Residence shall maintain a staff-to-resident ration of 1:8, twenty-four hours (24 hr.) per day whenever a resident is present and 2:8 during periods of peak activity, such as mealtimes and when most of the residents are home and awake.” D.C. Mun. Reg. tit. 22 §3836.4(1995). The regulations additionally require that, “An Intensive Residence shall have a staff-to-resident ratio of 2:8, for sixteen hours (16 hrs.) a day during awake hours, whenever a resident is present.” D.C. Mun. Reg. tit. 22 §3837.4(1995).

Oftentimes, ULS-P&A has visited MHCRFs to find inadequate numbers of staff on duty. Additionally, ULS-P&A has received complaints about staff shortages, usually because consumers are being refused entry, as previously discussed. The following examples illustrate violations of Chapter 38 staffing regulations:

- During ULS-P&A’s visit, a Supported Residence MHCRF had *only one staff member on duty* at dinnertime although there were approximately eighteen residents, a ratio of 1:18 rather than the required 1:8 staff-to-resident ratio during meal times.
- Mr. Hamilton, a consumer in an Intensive Residence MHCRF, was severely burned by one hundred and forty degree water in his shower because the staff had failed to check the temperature of the water after maintenance work was done. The staff informed ULS-P&A that there was only one member of staff on shift. However, the Regulations require a 2:8 staff-to-resident ratio during awake hours. Additionally, Mr. Hamilton usually requires staff assistance in order to shower. Mr. Hamilton’s health has drastically deteriorated since receiving his injuries.

Understaffing results in inadequate supervision of consumers and severely limits the opportunity for therapeutic interactions. Inadequate supervision places consumers at increased risk for injury, as demonstrated in the above example. The decrease in therapeutic interactions deprives consumers of the opportunity to work with staff on

independent living skills or other treatment plan goals. Understaffing has also resulted in consumers being denied access to the residence, as discussed earlier in this report.

To prevent staffing shortages, ULS-P&A recommends:

1. Increased monitoring of MHCRFS by DMH; and
2. Direct care staff receive better pay, increased support, and have more time off;
3. Sanctions are applied to MHCRFs that fail to comply.

VIII. MHCRFS DO NOT PROVIDE A HOME-LIKE ENVIRONMENT

The law: Chapter 38 of the D.C. Municipal Regulations require that, “Each residence shall be equipped, furnished, and maintained in such a manner as to provide a comfortable, congenial, home-like setting for each resident and staff member.” D.C. Mun. Reg. tit. 22 §3802.8(1995). Additionally, the Regulations require that, “The interior and exterior of each MHCRF shall be maintained in a safe, clean, orderly, attractive, sanitary manner and shall be free from accumulations of dirt, rubbish, and objectionable odors.” D.C. Mun. Reg. tit. 22 §3815.1(1995).

ULS-P&A has visited many MHCRFs that lack appropriate furniture, community space, and fail to provide a home-like environment. Specifically, ULS-P&A has found many MHCRFs lacking clean, comfortable furniture, without enough community space to accommodate all residents, and in need of repairs. ULS-P&A has visited MHCRFs lacking any indicators that the house is a home rather than an institution. Additionally, some MHCRFs are in unsafe areas, placing consumers at a heightened level of risk for becoming victims of crime. The following examples illustrate such deficiencies:

- One MHCRF’s community space consisted of only the dining room and a tiny television room that sat only about five of the fourteen residents. There did not appear to be a single couch or armchair in the house. The chairs in the dining room and the television room were an assortment of old, worn-out metal and plastic chairs.
- Another MHCRF had many large piles of rusty and broken furniture and hardware supplies in the backyard and two bathroom sinks that were on the verge of disconnecting from the wall. If a consumer were to lean on one of those sinks, it could fall and seriously injure the consumer.
- A consumer and a member of staff at another MHCRF told ULS-P&A that the residents are required to be in the house after dark because the area around the house is unsafe. Additionally, the consumer told ULS-P&A that he does not go places on weekends because the bus stop by the house is not safe. ULS-P&A has witnessed a drug sale less than a block from the MHCRF.

The negligent failure on the part of a considerable number of MHCRFs owners to keep their premises and furniture in good repair and the intentional failure to provide consumers with appropriate furniture and community space, demonstrates the low standards to which MHCRFs are held. The above conditions place consumers' health and safety at risk and certainly do not reflect comfortable, home-like settings. ULS-P&A recommends that:

1. MHCRFs not be licensed until they have established a home-like environment;
2. Regular maintenance be required and enforced in order to ensure consumer health and safety as MHCRFs become older and more likely to be run down;
3. Every attempt should be made to ensure that MHCRFs are not in high crime areas;
4. Sanctions are applied to MHCRFs that fail to comply.

IX. CONSUMERS ARE AT RISK FOR HEAT RELATED INJURIES IN NON AIR CONDITIONED MHCRFS

The law: Chapter 38 of the D.C. Municipal Regulations requires that, "Fans or air conditioning shall be available in sleeping rooms and in the main living room between April 15th and October 15th to maintain a maximum temperature of ninety degrees Fahrenheit (90° F.)." D.C. Mun. Reg. tit. 22 §3806.1(1995).

Many licensed MHCRFs are not equipped with air conditioning and/or have no air conditioning in consumers' bedrooms. The summers in the District of Columbia are extremely hot and elderly consumers and consumers on psychotropic medication have a greater than average risk for heat related injuries. In response to ULS-P&A's concerns about the stiflingly hot conditions in the upstairs bedrooms, the owners almost always explain that every bedroom is equipped with a fan. However, the regulations state that the maximum temperature must not surpass ninety degrees Fahrenheit, not that a MHCRF's responsibility is to simply provide each resident with a fan. The District's average high temperature in July is eighty-nine degrees Fahrenheit, therefore regularly surpassing ninety degrees Fahrenheit throughout the summer months. The following are examples of consumers at risk for heat related injuries due to lack of access to air conditioning:

- Ms. Sweeney and Ms. Nathan share a second floor bedroom in their MHCRF that has *neither a fan nor air conditioning*.
- Fourteen consumers, many of whom are elderly and some of whom are medically involved, live in a MHCRF that does not have a single air conditioning unit anywhere in the house.

- Approximately twenty elderly and mentally ill consumers live in a MHCRF that does not have air conditioning in any of the bedrooms. Most of the consumers live on the second floor.
- A resident in another MHCRF reported that she has to ask permission to open her bedroom window or to turn on the ceiling fan in her bedroom. The bedroom has no air conditioning.

The consumers living in these bedrooms have been needlessly subjected to health risks. A study of heat related deaths in New York Psychiatric facilities found that *the incidence of death among psychiatric patients during a heat wave was twice that of the general population*. The study also stated that anti-psychotic medications were a risk factor for heat stroke.² Furthermore, many consumers in MHCRFs have respiratory problems and medical complications which living in hot bedrooms could only worsen.

To avoid preventable heat related injury, ULS-P&A recommends that:

1. The Chapter 38 Regulations be *changed* to reflect ambient temperatures;
2. All consumers with respiratory health concerns have air conditioned bedrooms;
3. DMH provide incentives for MHCRFs to obtain air conditioning; and
4. All MHCRF resident deaths that occur in the summer should be investigated for the possibility of a heat related cause;
5. Sanctions are applied to MHCRFs that fail to comply.

X. CASE MANAGERS HAVE PLACED CONSUMERS IN AND NEGLIGENTLY ALLOWED CONSUMERS TO REMAIN IN UNINHABITABLE AND UNSAFE HOUSING

***DMH Requirements:** DMH requires that case managers who place consumers in rooming homes and other independent living situations “review all residences” and further states that “no consumers shall be placed in a rooming and/or boarding facility that does not have a proper license for this type of living situation and meets basic housing standards.” DMH protocol additionally requires that “If a consumer refuses to move, counsel the consumer about moving to decent and safe surroundings and offer the consumer opportunities to view other settings on a weekly basis.” See The Protocol for Placement and Evaluation of CMHS Consumers in Rooming/Boarding Homes and Other Independent Living Situations.*

Even more tragic than the conditions in the MHCRFs, are the conditions in the apartments and Supported Independent Living settings in which their case managers place many consumers. Many of these apartments and houses are filthy, insect and rodent infested, have no electricity, no heat, no running water, no phones, empty

² Nigel Bark, M.D., *Deaths of Psychiatric Patients During Heat Waves*, 49 *Psychiatric Services* 1088, 1090 (1998).

refrigerators, crusty stoves, no window screens, exposed wiring, peeling paint, broken and soiled furniture, and foul odors. Many consumers are placed in unsafe housing. Consumers have even been placed in a house with large amounts of drug traffic, one female consumer was mugged twice in the entryway of her building, and many homes have not passed fire inspection. The following examples speak for themselves:

- Mr. Nelson and several other consumers receiving case management from the same DMH contracted provider were placed in a house in horrifying condition. ULS-P&A was contacted because the consumers were complaining that there was no heat. ULS-P&A investigated and found that there was no heat, the house was filthy, there was no phone, and the case management agency was aware of these conditions. In response to ULS-P&A's complaints, DMH visited the house and found: a foul odor throughout the house; a mattress on the living room floor with very soiled linen, numerous cigarette butts and trash over the entire area; a bedroom that was both dirty and cluttered, with more very soiled linen on the bed, more cigarette butts and trash everywhere; the kitchen was found to be infested with roaches, there were dirty dishes strewn around, and again, trash and garbage all over the place as well as a burner in the gas stove turned up full; in the bathroom, the face bowl, toilet and bathtub were black with dirt and scum. In addition to these horrible and untenable conditions, the house had no electricity and no running water and no phone. The D.C. housing inspector made a site visit and found the temperature to be only fifty degrees Fahrenheit. According to the case management agency, the entire situation was due to the male consumers being "messy."
- Because attention was brought to the conditions described in the previous example, the consumers involved were moved to another residence, but the new residence was no more habitable than the first. Consumers complained that rodents were all over the house, people come and go all night, and there is a lot of drug activity going on there. In response to these complaints, ULS-P&A visited the house and found that: a strong odor permeated the house, which was almost unbearable; the bathroom had no shower curtain and the faucet head was off; there was no washer or dryer, no cleaning supplies, and the kitchen was not usable; cupboards had been smashed in and their doors ripped off; there was no heat; and there was *no* food.
- Her case manager placed Ms. Chang in an apartment. The apartment building is in a very unsafe area with heavy drug traffic. Her apartment is located on the second floor at the end of a long, dark hallway. Most of the apartments in the building are vacant. There are mice in the apartment, no screens on the windows, the floor is covered with a tacky substance, as the carpet was removed, but never replaced, and huge pieces of paint are

chipping out of the bathroom sink. Most disturbingly, Ms. Chang reports that she has been violently mugged twice in the entryway to the building.

- Mr. Cole called ULS-P&A because he was threatened with eviction from his apartment because it had become a serious health risk. Mr. Cole lives in his own apartment and receives case management services. Because of his mental illness, Mr. Cole has difficulty maintaining a clean apartment. As a result, his apartment became roach infested, the floors became sticky and the bed looked like an insect breeding ground. The air took on a persistent stench. Mr. Cole's case manager was aware of the worsening condition of the apartment, but failed to advocate on his behalf to find him assistance. Ultimately, ULS-P&A managed to arrange for the apartment to be cleaned, in an effort to try to prevent the eviction of Mr. Cole. Mr. Cole's case manager should have taken this kind of step.

Whether case managers knowingly place consumers in uninhabitable housing or they fail to inspect the housing before placing consumers, situations like the above constitute gross abuse and neglect and violate stated DMH protocol. There is no excuse for the continuation of such practices, which needlessly puts consumers' health and safety at risk.

To protect the health and safety of consumers, ULS-P&A recommends that:

1. Case managers visit housing before placing consumers, make regular home visits thereafter, and be required to contact all the appropriate D.C. government agencies, such as DOH, DCRA, and the Fire Marshall;
2. Contract case management providers be held accountable to DMH for housing placements through explicit contract sanctions;
3. Case managers work with daily living coaches and home health aids in order to promote the health and safety of consumers living independently and in need of help with the Activities of Daily Living (ADLs);
4. Case managers have access to emergency funds for emergency cleaning services and replacement furniture; and
5. Residential status should be made part of consumers' treatment plans;
6. Sanctions are applied to case managers that fail to comply.

XI. MHCRFS FAIL TO PROVIDE SOCIAL AND RECREATIONAL ACTIVITIES

The law: Chapter 38 of the D.C. Municipal Regulations requires that, "Each MHCRF shall provide or arrange for suitable activities sufficient to stimulate and promote the well-being of each resident, to encourage independence and maintenance of normal activities and to maintain and promote an optimal level of functioning." D.C. Mun. Reg. tit. 22 §3834.1(1995). The Regulations additionally, require that, "Each MHCRF shall provide or arrange for

*educational and skill building activities...such as...use of recreational time.”
D.C. Mun. Reg. tit. 22 §3834.4(1995).*

MHCRFs are not providing adequate social and recreational activities. As a result, consumers spend large amounts of time watching T.V. or sitting around rather than engaging in rehabilitative activities. At least 75% of consumers surveyed by ULS-P&A at day treatment programs reported that their after-dinner activity is watching T.V. Many consumers have complained to ULS-P&A that they are bored and would like more activities, especially over the weekend. Indeed, less than 10% of consumers surveyed reported any MHCRF organized weekend activity. The following examples illustrate:

- Mr. Perkins complains that he is bored at his MHCRF, which is an Intensive Residence (IR) level of care. He attends a day program, but reports that once he returns to the residence he has nothing to do with the rest of his day. In fact, IR MHCRFs are required to provide programming because some of their residents are likely to be unable to go out to programs.
- A MHCRF resident told ULS-P&A that if he could have one thing different it would be to have weekend activities. He stated that the neighborhood was not safe to walk around in and so it would be nice to have day trips planned over the weekend because weekends are long and boring.

Social and recreational activities are an essential element of a rehabilitative treatment. A common response from MHCRF owners and staff to advocates' complaints regarding the lack of social and recreational activities is that consumers would not participate anyway, that consumers would rather watch television. The above examples of consumers requesting more activities contradict such a response. Furthermore, considering the fact that most consumers have lived in MHCRFs for years without social stimulation, most consumers have probably adapted to the lack of social activity. A central goal of a rehabilitative system is to improve consumers' quality of life, and social and recreational opportunities are essential to achieving that goal.

ULS-P&A recommends that:

1. MHCRF licensing and evaluation take into consideration social and recreational programming;
2. The evaluation of case management should also take into consideration the support of consumer social and recreational activities; and
3. Social and recreational activities should be part of consumers' treatment plans;
4. Sanctions are applied to MHCRFs and case managers that fail to comply.

XII. MHCRFS HAVE ARBITRARY RULES THAT UNNECESSARILY LIMIT CONSUMER CHOICE AND FREEDOM

The law: D.C. Municipal Regulations require that, “ Each MHCRF shall...maintain as culturally normal routines and procedures as possible...similar to the living patterns of independent persons in the community.” D.C. Mun. Reg. tit. 22 §3832.2 (1995). In contradiction, the Regulations also require that, “At a minimum, each MHCRF shall have rules concerning the following: (a) The use of tobacco and alcohol; (b) The use of the telephone; (c) Hours for viewing or listening to television, radio or phonograph; and (d) Movement of residents in and out of the facility.” D.C. Mun. Reg. tit. 22 §3801.30(1995).

Consumers’ freedom and choice are restricted in MHCRFs by arbitrary house rules. For example, MHCRFs commonly enforce curfews and bedtimes, limited phone privileges, and set television times. Some MHCRFs actually require residents to go to their rooms immediately after dinner. Consumers typically are provided space for minimal personal belongings and are not allowed to personalize their rooms. Many MHCRFs restrict consumers’ right to have visitors, designating who can visit, where they can visit, and at what time they can visit. Most significantly, consumers who would benefit from a group home environment have not been able to because of the rigidity of MHCRF rules. The following examples illustrate:

- A long time resident of Saint Elizabeth Hospital was ready for community placement. Throughout the previous year he had an evening job, which had been a very positive development for him. He looked at a MHCRF that he liked, but the MHCRF refused to take him because of his evening job. *The MHCRF had a strict rule that that no resident is allowed to come in late or sleep-in in the morning.*
- As mentioned earlier in this report, Mr. Turner was refused entrance to his MHCRF at 4 a.m. and was forced to remain outside until later that morning. The owner of the MHCRF reported that she did not allow Mr. Turner in the house because it was after curfew time.
- One MHCRF limits consumer phone calls to five minutes. Additionally, there is *no phone* that consumer can use to have a private conversation.
- In another case, prior to moving-in to a MHCRF, most of the residents had lived in efficiencies or apartments. As reported by case managers and residents, the residents were all told they had to get rid of any furniture they owned before moving into the MHCRF. They reportedly were not even permitted to keep such items as a favorite desk or chair.

The current Chapter 38 Regulations require rules regarding phone use, television use, and when residents can come and go from the residence. Not only are these rules unnecessary, but also MHCRFs have applied them arbitrarily and too rigidly, as illustrated by the above examples. Arbitrary rules limit consumer choice and freedom while providing little or no benefit to the residents; such rules seem entirely for the convenience of MHCRF operators and staff. If a rule has clinical or safety purposes, MHCRFs should have discussions with residents, rather than impose them arbitrarily. For example, many MHCRFs say that they have curfews because the home is in a high crime area. Rather than hold residents hostage at night, MHCRFs could discuss safety concerns with residents, encourage them to be home before dark, and set-up a buddy system.

To ensure that MHCRF residents are not limited by arbitrary rules, ULS-P&A recommends that:

1. Chapter 38 Regulations should be changed so as to no longer *require* rules regarding phone use, television use, and when residents can come and go from the residence;
2. Licensing and inspection include consideration of reasonableness of house rules; and
3. MHCRFs should be required to hold weekly (at a minimum) house meetings for residents and staff to discuss rules and alternatives to rules and other issues;
4. Sanctions are applied to MHCRFs that fail to comply.

XIII. CONSUMERS ARE BEING DENIED THEIR RIGHT TO LIVE IN THE LEAST RESTRICTIVE SETTING

The law: Title II of the Americans with Disabilities Act (ADA) requires that, “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 CFR 35.130(d)(1998).

Many consumers are being denied their right to live in the least restrictive setting, a right guaranteed by the Americans with Disabilities Act. Consumers remain in MHCRFs who could live in Supported Independent Living settings; consumers live in more intensive levels of MHCRFs (i.e. SR, SRR, IR) who could live in less intensive levels; and consumers remain at Saint Elizabeth’s Hospital who could live in the community. A countless number of consumers tell ULS-P&A that they would like to move out of their MHCRF to a more independent setting, but that their case managers are unresponsive or refuse to provide the assistance necessary for them to do so. For example, a consumer living in a MHCRF reported to ULS-P&A that his case manager told him that if he wants to live in his own apartment, he would have to go find the apartment by himself and make his own arrangements.

The following are further examples of the denial of consumers' right to live in the least restrictive setting:

- During a visit to a MHCRF, two consumers told ULS-P&A that they feel they are ready to live in their own apartment. After decades of receiving services from DMH, one of the consumers said she believed the case managers feel consumers in MHCRFs should be thankful for a roof, a bed, and three meals a day. She felt that it is because of this kind of attitude that case managers are not helpful when consumers ask for help trying to move out of a MHCRF and into a more independent setting. She reports that her own case manager has not been helpful.
- Mr. Nelson has been at Saint Elizabeth's Hospital since May 2001 because his community providers have failed to find him housing, although he does not require a hospital level of care at this time.
- Ms. Cooper, who lives in a MHCRF, wants to live in a more independent setting. Ms. Cooper's case manager is not doing anything to help Ms. Cooper achieve this goal, clinically or logistically.

The denial of consumers' right to live in the least restrictive setting severely diminishes their opportunities for social integration and perpetuates the false image that the mentally ill cannot function in the community. Most consumers need some support in order to transition to a less restrictive setting. However, providers are not offering the necessary support, and therefore, are essentially confining consumers to their current level of care. Supports must include more than mere assistance finding an apartment or a less restrictive level of MHCRF. Development and training of the skills needed to live in a less restrictive setting must also be provided. Therefore, as previously discussed in this report, providers should involve consumers in activities such as the management of the consumer's finances and social and recreational activities. Similarly, MHCRFs can help develop such skills by involving consumers in decisions about house rules and what food is served and, most importantly, in the consumer's own treatment plan.

To ensure that consumers are not denied their right to treatment in the least restrictive setting, ULS-P&A recommends that:

1. Consumers' cases be reviewed at least twice annually to determine whether they are in the least restrictive setting;
2. Consumers be involved in their case review;
3. Treatment Plans focus on rehabilitation and increasing independence; and
4. DMH hold case managers accountable for ensuring that consumers are in the least restrictive setting.
5. Sanctions are applied to case managers and MHCRFs that fail to comply.

CONCLUSION

As illustrated by the examples in this report, there are serious deficiencies in the care individuals in the District of Columbia with mental illness are receiving in MHCRFs and from case management services. Moreover, most of ULS-P&A's findings involve clear violations of Chapter 38 of the D.C. Municipal Regulations. To summarize ULS-P&A's findings:

- Consumers have been verbally abused, sexually harassed, and discriminated against in many MHCRFs;
- Many MHCRFs fail to provide for consumers' basic needs, such as nutrition and safety;
- Many MHCRFs fail to provide a home-like and habilitative environment;
- Consumers' finances are not being safeguarded;
- In many instances, case managers have jeopardized consumers' health and safety by placing them in uninhabitable housing; and
- Consumers are often not receiving the necessary support to ensure they are living in the least restrictive setting.

Increased monitoring and the implementation of a consistent grievance procedure would reduce the occurrence of many of the inadequacies discussed in this report. Increased monitoring would also uncover instances of abuse, of consumers being refused entrance during the day, of financial exploitation, of lack of food and lack of household supplies, of under-staffing, and of unsafe and unsanitary conditions. Because abuses are often not readily apparent, monitoring should include methods such as interviews with residents and unannounced visits during meal times.

Even with such methods, the implementation of a *grievance procedure* is essential in order to uncover abuses that may not become apparent through monitoring alone. In response to the Auditor's report, DMH stated that it would implement a grievance procedure and provide a training program for staff, owners, providers, and operators. In order for such a grievance procedure to be effective, *consumers*, in addition to service providers, must be informed and trained on how to use the procedure.

Other findings discussed in this report require a shift in providers' attitude towards a more rehabilitative approach to services. Under a habilitative approach, MHCRFs would provide services that foster a level of functioning and self-sufficiency consistent with each consumer's ability. For example, consumers with representative payees would be involved in the management of their finances, MHCRFs would provide social and recreational opportunities, and residents would be involved in the creation of house rules. The ultimate goal of a habilitative approach is for consumers to acquire the skills necessary to live in a less restrictive setting. To effectuate a habilitative approach to services, MHCRF licensing and monitoring and performance reviews of case managers must take into account the provision of such services. Additionally, the direct care staff at MHCRFs must receive the training, supervision, and supports necessary both to learn

how to work with consumers in a positive, supportive manner, as well as to learn more about the residents' disabilities.

To conclude, case managers must be held accountable for the mismanagement of consumer funds, placing consumers in uninhabitable housing, and failing to help consumers live in the least restrictive setting. Primarily, when case managers serve as representative payee, they must closely monitor consumer accounts so that consumers never suffer financial loss because of a case managers' negligence. If the Office of Patient Accounts is not providing case managers with timely and necessary information about consumers' accounts, then DMH's system of managing consumer funds needs to be overhauled. In addition, case managers must conduct reasonable investigations before placing consumers in independent living or supported independent living settings. Finally, case managers must ensure that consumers are in the least restrictive setting by coordinating treatment team meetings and case reviews, at which housing and independent living skills are discussed.

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